		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044057

Facility Name: Salem Village Nursing

Address: 1314 Rowell Ave (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-5451 **Fax #** (815) 727-9413

IDPA ID Number: 431823694001

Date of Initial License for Current Owners: 08/31/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,692	1
2		Skilled Pediatric (SNF/PED)			2
3	204	Intermediate (ICF)	204	74,664	3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,196	5
6		ICF/DD 16 or Less			6
7	272	TOTALS	272	99,552	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,954	134	15,287	17,375	8
9	SNF/PED					9
10	ICF	45,194	10,499	3,027	58,720	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,148	10,633	18,314	76,095	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.44%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/31/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 14,534

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	361,220	38,214	16,361	415,795		415,795		415,795			1
2	Food Purchase		363,709		363,709		363,709	(508)	363,201			2
3	Housekeeping	273,594	46,020		319,614		319,614		319,614			3
4	Laundry	102,951	23,455		126,406		126,406		126,406			4
5	Heat and Other Utilities			249,757	249,757		249,757		249,757			5
6	Maintenance	111,457	20,365	173,335	305,157		305,157	(17,567)	287,590			6
7	Other (specify):*											7
8	**TOTAL General Services**	849,222	491,763	439,453	1,780,438		1,780,438	(18,075)	1,762,363			8
	B. Health Care and Programs											
9	Medical Director			32,400	32,400		32,400		32,400			9
10	Nursing and Medical Records	3,467,024	190,928	11,382	3,669,334		3,669,334		3,669,334			10
10a	Therapy	163,240		2,436	165,676		165,676	10,015	175,691			10a
11	Activities	149,693	7,671	6,415	163,779		163,779		163,779			11
12	Social Services	94,518		2,822	97,340		97,340		97,340			12
13	Nurse Aide Training											13
14	Program Transportation			1,751	1,751		1,751		1,751			14
15	Other (specify):*							1,876	1,876			15
16	**TOTAL Health Care and Programs**	3,874,475	198,599	57,206	4,130,280		4,130,280	11,891	4,142,171			16
	C. General Administration											
17	Administrative	107,764		353,500	461,264		461,264	(221,629)	239,635			17
18	Directors Fees											18
19	Professional Services			110,679	110,679		110,679	(26,726)	83,953			19
20	Dues, Fees, Subscriptions & Promotions			87,049	87,049		87,049	(24,194)	62,855			20
21	Clerical & General Office Expenses	350,313		336,814	687,127		687,127	(52,789)	634,338			21
22	Employee Benefits & Payroll Taxes			916,086	916,086		916,086		916,086			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,499	1,499		1,499	289	1,788			24
25	Other Admin. Staff Transportation			58,915	58,915		58,915	(26,804)	32,111			25
26	Insurance-Prop.Liab.Malpractice			187,708	187,708		187,708	104	187,812			26
27	Other (specify):*							25,936	25,936			27
28	**TOTAL General Administration**	458,077		2,052,250	2,510,327		2,510,327	(325,813)	2,184,514			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,181,774	690,362	2,548,909	8,421,045		8,421,045	(331,997)	8,089,048			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Salem Village Nursing #0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			155,146	155,146		155,146	401,002	556,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,344	105,344		105,344	442,452	547,796			32
33	Real Estate Taxes			100,082	100,082		100,082		100,082			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,060,355)	19,645			34
35	Rent-Equipment & Vehicles			42,822	42,822		42,822	(4,275)	38,547			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,483,394	1,483,394		1,483,394	(221,176)	1,262,218			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,577,154	77,636	1,654,790		1,654,790		1,654,790			39
40	Barber and Beauty Shops			449	449		449		449			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,034	146,034		146,034		146,034			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,577,154	224,119	1,801,273		1,801,273		1,801,273			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,181,774	2,267,516	4,256,422	11,705,712		11,705,712	(553,173)	11,152,539			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	192,321	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(508)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,954)	21		18
19	Entertainment				19
20	Contributions	(3,620)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,238)	21		24
25	Fund Raising, Advertising and Promotional	(20,463)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(247,632)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,094)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(393,079)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (393,079)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (553,173)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Salem Village Nursing

ID# 0044057

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (2,076)	21	1
2	Cable Expense	(16,787)	21	2
3	Capitalized R & M	(18,415)	06	3
4	Non-Allowable Expense	(120,000)	21	4
5	COPE Dues	(986)	20	5
6	Misc. Expense	(16,118)	21	6
7	Out of Period Legal Fees	(14,234)	19	7
8	Non-Allowable Legal Fees	(20,070)	19	8
9	Direct TV	(6,524)	35	9
10	Non-Allowable Auto Lease	(32,422)	25	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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100				100
101	Total	(247,632)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(508)											(508)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(18,415)		848									(17,567)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(18,923)		848									(18,075)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy			10,015									10,015	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			1,876									1,876	15
16	**TOTAL Health Care and Programs**			11,891									11,891	16
	C. General Administration													
17	Administrative			(221,629)									(221,629)	17
18	Directors Fees													18
19	Professional Services	(34,304)		7,578									(26,726)	19
20	Fees, Subscriptions & Promotions	(25,069)		875									(24,194)	20
21	Clerical & General Office Expenses	(235,173)	(10)	182,394									(52,789)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			289									289	24
25	Other Admin. Staff Transportation	(32,422)		5,618									(26,804)	25
26	Insurance-Prop.Liab.Malpractice			104									104	26
27	Other (specify):*			25,936									25,936	27
28	**TOTAL General Administration**	(326,968)	(10)	1,165									(325,813)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(345,891)	(10)	13,904									(331,997)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	192,321	205,674	3,007									401,002	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		441,810	642									442,452	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,080,000)	19,645									(1,060,355)	34
35	Rent-Equipment & Vehicles	(6,524)		2,249									(4,275)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	185,797	(432,516)	25,543									(221,176)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(160,094)	(432,526)	39,447									(553,173)	45

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,080,000	Salem Village Properties	100.00%	$	$ (1,080,000)	1
2	V	30	Depreciation		Salem Village Properties	100.00%	205,674	205,674	2
3	V	32	Interest Expense		Salem Village Properties	100.00%	441,810	441,810	3
4	V	21	Misc. Income		Salem Village Properties	100.00%	(10)	(10)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,080,000			$ 647,474	$ * (432,526)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS & MAINTENANCE	$	HEALTHCARE MNGMNT. ASSOC.	100.00%	$ 848	$ 848	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	7,578	7,578	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	875	875	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	15,180	15,180	18
19	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	289	289	19
20	V	25	TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,618	5,618	20
21	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	104	104	21
22	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	68	68	22
23	V	30	DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	3,007	3,007	23
24	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	19,645	19,645	24
25	V	32	INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	642	642	25
26	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,249	2,249	26
27	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	115,712	115,712	27
28	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	17,960	17,960	28
29	V	10a	REHAB		HEALTHCARE MNGMNT. ASSOC.	100.00%	10,015	10,015	29
30	V	15	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,876	1,876	30
31	V	21	CLERICAL SALARY		HEALTHCARE MNGMNT. ASSOC.	100.00%	51,502	51,502	31
32	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,371	6,371	32
33	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	14,371	14,371	33
34	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,537	1,537	34
35	V	17	MANAGEMENT FEE	236,000	HEALTHCARE MNGMNT. ASSOC.	100.00%		(236,000)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 236,000			$ 275,447	$ * 39,447	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Mark Suissa	Owner	Administrative	22.50%	See Attached	17.74	29.57%	Alloc. Sal,Fees	$ 74,371	17-7,17-3	1
2	Eric Simon	Relative	Administrative		See Attached	40.00	100.00%	Alloc. Sal,Fees	109,002	17-7,17-3	2
3	Lorraine Suissa	Owner	Administrative	22.50%	See Attached	40.00	100.00%	Salary	35,006	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 218,379		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTHCARE MNGMNT. ASSOC.
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	ILL. & MO. PAT. DAYS	257,791	6	$ 2,869	$	76,201	$ 848	1
2	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	257,791	6	25,638		76,201	7,578	2
3	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	257,791	6	2,961		76,201	875	3
4	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	257,791	6	51,356		76,201	15,180	4
5	24	SEMINAR	ILL. & MO. PAT. DAYS	257,791	6	977		76,201	289	5
6	25	TRAVEL	ILL. & MO. PAT. DAYS	257,791	6	19,007		76,201	5,618	6
7	26	INSURANCE	ILL. & MO. PAT. DAYS	257,791	6	352		76,201	104	7
8	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	257,791	6	230		76,201	68	8
9	30	DEPRECIATION	ILL. & MO. PAT. DAYS	257,791	6	10,174		76,201	3,007	9
10	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	257,791	6	66,459		76,201	19,645	10
11	32	INTEREST	ILL. & MO. PAT. DAYS	257,791	6	2,172		76,201	642	11
12	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	257,791	6	7,608		76,201	2,249	12
13	21	CLERICAL SALARIES	ILL. & MO. PAT. DAYS	257,791	6	391,457	391,457	76,201	115,712	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL. & MO. PAT. DAYS	257,791	6	60,761		76,201	17,960	14
15	10a	REHAB	ILL. PAT. DAYS	132,734	4	17,445	17,445	76,201	10,015	15
16	15	EMPLOYEE BENEFITS	ILL. PAT. DAYS	132,734	4	3,267		76,201	1,876	16
17	21	CLERICAL SALARY	DIRECT		1	51,502	51,502		51,502	17
18	27	EMPLOYEE BENEFITS	DIRECT		1	6,371			6,371	18
19	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	6	48,616	48,616	18	14,371	19
20	27	EMP. BEN.-M. SUISSA	AVG. HOURS WORKED	60	6	5,200		18	1,537	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 774,422	$ 509,020		$ 275,447	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American National Bank		X	Mortgage			$	$ 6,546,964			$ 441,810	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank One		X	Line of Credit				730,000		Prime+1%	105,344	6
7	Alloc. From HMA		X								642	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 7,276,964			$ 547,796	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 7,276,964			$ 547,796	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 115,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 107,683	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,917)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 108,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 100,083	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	91,910	8
	2000	96,786	9
	2001	101,015	10
	2002	108,071	11
	2003	107,683	12

Accrual = $107,683 x 1.003 = $108,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-23-304-011-0000	Long Term Care Property	$ 107,048.40	$ 107,048.40
2.	30-07-23-304-007-0000	Long Term Care Property	$ 145.24	$ 145.24
3.	30-07-23-304-010-0000	Long Term Care Property	$ 488.96	$ 488.96
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 107,682.60	$ 107,682.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,847 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 408,000	1
2					2
3	TOTALS			$ 408,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	5,427	5,427	33,673	9
10	Various			1999	240,599		20	12,194	12,194	63,019	10
11	Various			2000	193,202		20	9,665	9,665	46,183	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		8,021,280	205,674		401,064	195,390	2,540,072	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			155,146			(155,146)		69
70	TOTAL (lines 4 thru 69)		$ 8,563,596	$ 360,820		$ 428,350	$ 67,530	$ 2,682,947	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,563,596	$ 360,820		$ 428,350	$ 67,530	$ 2,682,947	1
2	Handrails	2001	2,805		20	140	140	561	2
3	Baseboards	2001	1,108		20	55	55	221	3
4	Drywall	2001	4,109		20	205	205	821	4
5	Handrails	2001	8,502		20	425	425	1,700	5
6	Wallcoverings	2001	10,640		20	532	532	2,084	6
7	Drywall	2001	1,825		20	91	91	357	7
8	Handrails	2001	7,606		20	380	380	1,458	8
9	Handrails	2001	13,970		20	699	699	2,504	9
10	Handrails	2001	7,081		20	354	354	1,239	10
11	Handrails	2001	6,670		20	334	334	1,085	11
12	Fencing	2001	8,200		20	410	410	1,264	12
13	Alarm System	2001	1,468		20	73	73	263	13
14	Alarm System	2001	4,250		20	213	213	762	14
15	Hvac Repairs	2001	5,283		20	264	264	1,012	15
16	Fire Alarm Repair	2001			20				16
17	Plumbing Repairs	2001	1,539		20	77	77	270	17
18	Electrical Repairs	2001	4,220		20	422	422	1,477	18
19	Heater Booster	2001	1,442		20	72	72	246	19
20	Kitchen Electrical	2001	520		20	26	26	80	20
21	Doors	2001	1,779		20	89	89	356	21
22	Mail Boxes	2001	1,635		20	82	82	279	22
23	Janitor Sink Repairs	2001	1,534		20	77	77	294	23
24	Fire Alarm Repair	2001	2,395		20	120	120	419	24
25	Pump Repairs	2001	950		20	48	48	167	25
26	Walk In Freezer Rpr	2001	690		20	35	35	122	26
27	Cooler Repairs	2001	1,424		20	71	71	238	27
28	Janitor'S Sink	2001	1,577		20	79	79	303	28
29	Fire Alarm Repair	2001	502		20	25	25	88	29
30	Boiler Pump	2001	950		20	48	48	167	30
31	Walk In Freezer	2001	690		20	35	35	122	31
32	Washer Repairs	2001	996		20	50	50	174	32
33	Cooler Repairs	2001	1,424		20	71	71	238	33
34	TOTAL (lines 1 thru 33)		$ 8,671,380	$ 360,820		$ 433,952	$ 73,132	$ 2,703,318	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,671,380	$ 360,820		$ 433,952	$ 73,132	$ 2,703,318	1
2	Alarm Repairs	2001	855		20	43	43	142	2
3	Phones	2001	3,385		20	169	169	677	3
4	Phones	2001	3,247		20	162	162	595	4
5	Bathroom Vinyl Flooring	2002	6,422		20	428	428	1,284	5
6	Construction Of Wall	2002	935		20	94	94	265	6
7	Water Heater	2002	7,000		20	583	583	1,653	7
8	Kitchen Water Heater	2002	4,525		20	377	377	1,037	8
9	Window Installation	2002	2,033		20	203	203	525	9
10	Sat-T-Lok Systems	2002	4,956		20	708	708	1,888	10
11	Duro-Last Roof	2002	34,750		20	3,475	3,475	9,556	11
12	Remodeling	2002	7,500		20	750	750	1,875	12
13	Drain Line Repair	2002	1,274		20	127	127	372	13
14	Basement Repair	2002	1,197		20	120	120	349	14
15	Plumbing Repair	2002	1,376		20	138	138	401	15
16	Rewire Garbage Disposal	2002	583		20	58	58	175	16
17	Remove Debris	2002	1,500		20	150	150	438	17
18	Hot Water Repair	2002	513		20	51	51	154	18
19	Door Hinges	2002	608		20	61	61	172	19
20	Oak Strp Lam	2002	1,752		20	175	175	482	20
21	Tac-Compressor	2002	1,204		20	120	120	321	21
22	Seat Lift	2002	622		20	62	62	166	22
23	Mirror	2002	607		20	61	61	167	23
24	Refrig Repair	2002	688		20	69	69	172	24
25	Toilet	2002	758		20	76	76	183	25
26	Custom Door	2002	904		20	90	90	218	26
27	Seat Lift	2002	568		20	57	57	133	27
28	Toilet	2002	696		20	70	70	209	28
29	Custom Door	2002	603		20	60	60	141	29
30	Walk-In-Freezer	2002	645		20	65	65	177	30
31	Fixture Wall Mount	2002	1,027		20	103	103	240	31
32	Bracket Fixture	2002	1,159		20	116	116	261	32
33	Bracket Fixture	2002	636		20	64	64	143	33
34	TOTAL (lines 1 thru 33)		$ 8,765,908	$ 360,820		$ 442,837	$ 82,017	$ 2,727,889	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,765,908	$ 360,820		$ 442,837	$ 82,017	$ 2,727,889	1
2	Bracket Fixture	2002	890		20	89	89	200	2
3	Gas Valves	2002	1,089		20	109	109	236	3
4	Floor Repair	2002	520		20	52	52	113	4
5	Call System	2002	535		20	54	54	111	5
6	Bracket Fixture	2002	3,145		20	315	315	655	6
7	Repair Generator	2002	916		20	46	46	99	7
8	Drain Line Repair	2002	1,252		20	125	125	303	8
9	Hot Water Repair	2002	525		20	53	53	131	9
10	Sump Pumps	2003	1,900		20	380	380	665	10
11	Windows Various	2003	2,033		20	203	203	356	11
12	Nurse Call System	2003	8,500		20	567	567	944	12
13	Windows Various	2003	1,088		20	109	109	181	13
14	Heater Repairs	2003	3,400		20	340	340	538	14
15	Compressor	2003	2,650		20	530	530	795	15
16	Evaporating Coil	2003	1,600		20	320	320	480	16
17	Elctrical Work	2003	3,049		20	305	305	407	17
18	Air Compressor	2003	8,500		20	1,700	1,700	1,983	18
19	Nurses Station Annunciator	2003	837		20	84	84	112	19
20	Door Exit Device & Touch Pad	2003	991		20	99	99	124	20
21	Repair Ceiling Leak	2003	1,575		20	158	158	236	21
22	Door Rollers	2003	833		20	83	83	118	22
23	Walk-In Cooler Base Trim	2003	1,205		20	121	121	221	23
24	Entry Knobset	2003	621		20	62	62	93	24
25	New Motor For Tray Line	2003	1,233		20	123	123	216	25
26	Toilet Supports & Seat Lifts	2003	579		20	58	58	87	26
27	Toilet Supports & Supply Kits	2003	1,446		20	145	145	253	27
28	Repair Pvc Drain Line	2003	1,427		20	143	143	190	28
29	Repair Drain Line And Toilet Flange	2003	876		20	88	88	153	29
30	Install Gas Line And Condensor Motor	2003	1,190		20	119	119	238	30
31	Doors Emp Entrance	2004	2,050		20	171	171	171	31
32	Resident Bathrooms	2004	23,400		20	1,365	1,365	1,365	32
33	Pedestian Door Repair	2004	964		20	72	72	72	33
34	TOTAL (lines 1 thru 33)		$ 8,846,727	$ 360,820		$ 451,025	$ 90,205	$ 2,739,735	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,846,727	$ 360,820		$ 451,025	$ 90,205	$ 2,739,735	1
2	Elevator Packings	2004	1,700		20	99	99	99	2
3	Drapes Dining & Lobby	2004	6,501		20	379	379	379	3
4	Wall Covering	2004	5,421		20	3,162	3,162	3,162	4
5	Heat Exch Repair	2004	1,870		20	94	94	94	5
6	Water Heater Repair	2004	6,478		20	180	180	180	6
7	Resident Bathrooms	2004	22,564		20	1,504	1,504	1,504	7
8	Wallcovering	2004	1,790		20	746	746	746	8
9	Wallcovering	2004	4,820		20	2,812	2,812	2,812	9
10	Wallcovering	2004	903		20	151	151	151	10
11	Handrails	2004	5,950		20	99	99	99	11
12	Concrete Entrance Ramp	2004	2,850		20	32	32	32	12
13	Carpeting	2004	5,382		20	128	128	128	13
14	Carpeting	2004	2,712		20	65	65	65	14
15	Carpeting	2004	2,755		20	66	66	66	15
16	Phone Systm Repairs	2004	1,468		20	135	135	135	16
17	Condensing Unit Repair	2004	3,012		20	552	552	552	17
18	Leaking Pipe Repair	2004	1,219		20	5	5	5	18
19	Install Wallcover 2Nd Floor Halls	2004	1,855		20	15	15	15	19
20	Install Wallcover Lobby And Atrium	2004	1,861		20	16	16	16	20
21	Repaired Walk-In Cooler	2004	735		20	6	6	6	21
22	Repired Cooling Unit	2004	763		20	22	22	22	22
23	Replace Seitch-Kitchen Storage	2004	550		20	18	18	18	23
24	Repaired Water Leak-Kitchen Area	2004	945		20	43	43	43	24
25	Installed New Motor For Water Heater	2004	793		20	36	36	36	25
26	Motor Repair	2004	630		20	29	29	29	26
27	Repair & Seal Leaking Pipe	2004	750		20	31	31	31	27
28	Repaired Entry Door	2004	738		20	3	3	3	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,933,742	$ 360,820		$ 461,453	$ 100,633	$ 2,750,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998	1976	$ 8,021,280	$ 205,674		$ 401,064	$ 195,390	$ 2,540,072	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,021,280	$ 205,674		$ 401,064	$ 195,390	$ 2,540,072	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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21											21
22											22
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 617,493	$ 1,411	$ 77,685	$ 76,274	10	$ 301,362	71
72	Current Year Purchases	113,813	1,596	17,010	15,414	10	17,010	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 731,306	$ 3,007	$ 94,695	$ 91,688		$ 318,372	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,073,048	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 363,827	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 556,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 192,321	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,068,535	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Alloc. HMA				19,645			6
7	TOTAL				$ 19,645 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 29,733 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lexus ES 300 2003	$ 535.00	$ 6,420	17
18	Facility	Ford Mountainer 2002	486.00	2,394	18
19					19
20					20
21	TOTAL		$ 1,021.00	$ 8,814	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 02	hrs	$		$	$ 519,776		$ 519,776	1
2	Licensed Speech and Language Development Therapist	39 - 02	hrs				42,931		42,931	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 02	hrs				572,904		572,904	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				441,543		441,543	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					77,636			77,636	13
14	TOTAL			$		$ 77,636	$ 1,577,154		$ 1,654,790	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 70,902	$ 73,037	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,853,737	1,853,737	3
4	Supply Inventory (priced at)	18,137	18,137	4
5	Short-Term Investments			5
6	Prepaid Insurance	197,302	197,302	6
7	Other Prepaid Expenses	1,102	1,102	7
8	Accounts Receivable (owners or related parties)	900,864	444,860	8
9	Other(specify): See Attached Schedule	702	702	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,042,746	$ 2,588,877	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,021,280	14
15	Leasehold Improvements, at Historical Cost	727,882	727,882	15
16	Equipment, at Historical Cost	768,654	1,584,654	16
17	Accumulated Depreciation (book methods)	(903,559)	(3,022,160)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 592,977	$ 7,719,656	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,635,723	$ 10,308,533	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 315,771	$ 315,771	26
27	Officer's Accounts Payable	60,000	60,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	378,532	378,532	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,316	23,316	31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,000	108,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,425,940	65,233	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,311,559	$ 950,852	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	730,000	730,000	39
40	Mortgage Payable		6,546,964	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	102,051	102,051	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 832,051	$ 7,379,015	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,143,610	$ 8,329,867	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 492,113	$ 1,978,666	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,635,723	$ 10,308,533	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (362,238)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (362,238)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	854,351	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 854,351	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 492,113	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,238,395	1
2	Discounts and Allowances for all Levels	(2,022,205)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,216,190	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,908,711	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,908,711	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	372,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,042	19
20	Radiology and X-Ray		20
21	Other Medical Services	19,301	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 432,734	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,428	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,428	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,560,063	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,780,438	31
32	Health Care	4,130,280	32
33	General Administration	2,510,327	33
	B. Capital Expense		
34	Ownership	1,483,394	34
	C. Ancillary Expense		
35	Special Cost Centers	1,655,239	35
36	Provider Participation Fee	146,034	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,705,712	40
41	**Income before Income Taxes (line 30 minus line 40)****	854,351	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 854,351	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,300	2,506	$ 106,387	$ 42.45	1
2	Assistant Director of Nursing	5,317	5,963	175,674	29.46	2
3	Registered Nurses	40,469	42,878	1,043,224	24.33	3
4	Licensed Practical Nurses	28,769	30,604	611,158	19.97	4
5	Nurse Aides & Orderlies	143,075	148,022	1,481,700	10.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,114	14,195	163,240	11.50	8
9	Activity Director	2,311	2,595	34,388	13.25	9
10	Activity Assistants	13,813	14,689	115,305	7.85	10
11	Social Service Workers	6,670	7,344	94,518	12.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,339	46,370	361,220	7.79	15
16	Dishwashers					16
17	Maintenance Workers	4,840	5,078	111,457	21.95	17
18	Housekeepers	35,140	36,724	273,594	7.45	18
19	Laundry	12,806	13,423	102,951	7.67	19
20	Administrator	2,799	3,041	107,764	35.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,907	16,203	350,313	21.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,953	2,114	48,881	23.12	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	372,622	391,748	$ 5,181,774 *	$ 13.23	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	378	$ 16,361	01-03	35
36	Medical Director	Monthly	32,400	09-03	36
37	Medical Records Consultant	Monthly	4,330	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,666	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	25	2,436	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	111	6,415	11-03	44
45	Social Service Consultant	45	2,822	12-03	45
46	Other(specify)				46
47	Behavioral Consultant		4,386	10-03	47
48					48
49	TOTAL (lines 35 - 48)	559	$ 71,816		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paliwoda Kenneth	Administrator	0	$ 72,758
Lorraine Suissa	Administrative	45	35,006
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,764

B. Administrative - Other

Description	Amount
Healthcare Management - Home Office	$ 236,000
M. Suissa - Management Fee	60,000
E. Simon-Management Fees	57,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 353,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 28,645
See Attached	Legal	80,043
Personnel Planners	Unemployment Cslt.	1,991
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 110,679

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 271,379
Unemployment Compensation Insurance	
FICA Taxes	396,406
Employee Health Insurance	241,788
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	2,588
	3,925
TOTAL (agree to Schedule V, line 22, col.8)	$ 916,086

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	34,548
Health Care Worker Background Check	2,500
(Indicate # of checks performed 292)	
Dues & Subscribtions	7,587
Licenses & Fees	17,345
Alloc. From HMA	875
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,855

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,499
Alloc. From HMA	289
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,788

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,775** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **146,034**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.